Health General

§ 19-710. Basic requirements to operate as a health maintenance organization, Section
(h)(2)(i) Hold harmless clause (page224) and
(h)(2)(p) Enrollee not liable for covered services; exceptions (page 226)

Editor's note. — Section 8, chs. 111 and 112, Acts 1998, effective Jan. 1, 1999, provides that "the provisions of this Act shall apply to:

(a) all health insurance policies, plans, and contracts existing on and issued on or after January 1, 1999; and

(b) all adverse decisions rendered on or after January 1, 1999."

§ 19-709. Initial fees.

(a) *Application fee.* — When a health maintenance organization files its initial application for a certificate of authority to operate, it shall pay to the Commissioner a fee of $300.

(b) *Investigation fee.* — In addition to the fee required under subsection (a) of this section, each health maintenance organization shall pay a reasonable sum that the Commissioner finds to be the cost of the investigations made by the Commissioner and the Department as required under this subtitle. (An. Code 1957, art. 43, § 844; 1982, ch. 21, § 2; 1986, ch. 441; 1988, chs. 395, 754.)

§ 19-710. Basic requirements to operate as a health maintenance organization.

(a) *In general.* — To qualify for a certificate of authority to operate as a health maintenance organization, an applicant shall satisfy the Commissioner that the applicant will meet the requirements of this section.

(b) *Conformance with definition.* — The applicant shall conform to the definition of a health maintenance organization.

(c) *Appropriate health care plan.* — The applicant shall establish and operate a bona fide health maintenance organization that can provide health care services in the proposed geographic area.

(d) *Actuarial soundness and net worth.* — (1) The health maintenance organization shall be actuarially sound.

(2) (i) Except as otherwise provided in this paragraph, the surplus that the health maintenance organization is required to have shall be paid in full.

(ii) The health maintenance organization licensed on or after July 1, 1989 shall have an initial surplus that exceeds the liabilities of the health maintenance organization by at least $1,500,000.

(iii) All health maintenance organizations shall maintain a surplus that exceeds the liabilities of the health maintenance organization in the amount that is at least equal to the greater of $750,000 or 5 percent of the subscription charges earned during the prior calendar year as recorded in the annual report filed by the health maintenance organization with the Commissioner.

(iv) No health maintenance organization shall be required to maintain a surplus in excess of a value of $3,000,000.

(3) (i) For the protection of the health maintenance organization's members and creditors, the applicant shall deposit and maintain in trust with the State Treasurer $100,000 in cash or government securities of the type described in § 5-701(b) of the Insurance Article.

(ii) 1. The deposits shall be accepted and held in trust by the State Treasurer in accordance with Title 5, Subtitle 7 of the Insurance Article.

2. For the purpose of applying this subparagraph, a health maintenance organization shall be treated as an insurer.

(4) The Commissioner may waive the surplus and deposit requirements contained in this subsection if the Commissioner is satisfied that:

(i) The health maintenance organization has sufficient net worth and an adequate history of generating net income to assure financial viability for the next year;

(ii) The health maintenance organization's performance and obligations are guaranteed by another person with sufficient net worth and an adequate history of generating net income; or

(iii) The assets of the health maintenance organization or contracts with insurers, governments, providers, or other persons are sufficient to reasonably assure the performance of the health maintenance organization's obligations.

(e) *Applicability of Title 4, Subtitle 3 of the Insurance Article.* — The provisions of Title 4, Subtitle 3 of the Insurance Article (Risk Based Capital Standards for Insurers) apply to health maintenance organizations in the same manner as they apply to insurers.

(f) *Terms of contracts.* — The terms of contracts, including any medical assistance program contracts under Title XVIII or Title XIX of the Social Security Act or Title III of the Public Health Service Act, proposed to be made or made with government or private agencies that cover all or part of the cost of subscriptions to provide health care services, facilities, appliances, medicines, or supplies shall be financially sound, based on reasonable actuarial assumptions that the health maintenance organization can meet its obligations to the agencies and their beneficiaries by reason of the health maintenance organization's net worth position, stop loss, reinsurance arrangements with authorized insurers, or other arrangements that are satisfactory to the Commissioner.

(g) *Standards of quality and care.* — (1) The terms of the contracts to be offered to subscribers shall provide that the health care services provided to members of the health maintenance organization will meet reasonable standards of quality of care that are applicable to the geographic area to be served, as approved by the Department.

(2) If a health maintenance organization offers services that are within the scope of practice of a physician and another health care practitioner who is licensed under the Health Occupations Article, the health maintenance organization shall offer those services through other licensed health care practitioners, where appropriate, as determined by the health maintenance organization.

(h) *Lack of discrimination.* — The procedures for offering health care services and offering and terminating contracts to subscribers may not discriminate unfairly on the basis of age, sex, race, health, or economic status. This requirement does not prohibit:

(1) Reasonable underwriting classifications for establishing contract rates; or

(2) Experience rating.

(i) *Hold harmless clause.* — (1) The terms of the agreements between a health maintenance organization and providers of health services shall contain a "hold harmless" clause.

(2) The hold harmless clause shall provide that the provider may not, under any circumstances, including nonpayment of moneys due the providers by the health maintenance organization, insolvency of the health maintenance organization, or breach of the provider contract, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, member, enrollee, patient, or any persons other than the health maintenance organization acting on their behalf, for services provided in accordance with the provider contract.

(3) Collection from the subscriber or member of copayments or supplemental charges in accordance with the terms of the subscriber's contract with the health maintenance organization, or charges for services not covered under the subscriber's contract, may be excluded from the hold harmless clause.

(4) Each provider contract shall state that the hold harmless clause will survive the termination of the provider contract, regardless of the cause of termination.

(j) *Insurance.* — The health maintenance organization shall provide evidence of adequate insurance coverage or an adequate plan for self-insurance to satisfy claims for injuries that may occur from providing health care.

(k) *Audit and review.* — The health maintenance organization shall provide for having its health and medical facilities and services audited and reviewed periodically:

(1) By personnel outside the health maintenance organization who:

(i) Act in a manner that is approved by the Department; and

(ii) Use methods that will assure objective evaluation and keep the identity of patients as confidential as possible;

(2) By the health maintenance organization's own internal quality of care committee audit procedures, if the Department approves the procedures; or

(3) By a professional standards review organization, as described in Title XI of the Social Security Act, that is certified by the Department of Health and Human Services as capable of serving individuals in the area where the health maintenance organization operates who are receiving benefits under Title XVIII or Title XIX of the Social Security Act or Title III of the Public Health Service Act, if the professional standards review organization is acting consistently with its certification.

(l) *Internal peer review.* — (1) With the approval of the Department, the health maintenance organization shall provide continous internal peer review for monitoring and evaluating patient records for:

(i) Quality of care; and

(ii) Overuse and underuse of provider care; and

(2) The health maintenance organization shall meet the requirements of Subtitle 13 of this title and all regulations for the performance of utilization review.

(m) *Internal grievance system.* — The health maintenance organization shall provide an internal grievance system to resolve adequately any grievances initiated by any of its members, in a manner approved by the Department on matters concerning quality of care and by the Commissioner on all other matters covered by this subtitle, under rules and regulations adopted under this subtitle.

(n) *Participation by members.* — The health maintenance organization shall establish procedures to offer each member an opportunity to participate in matters of policy and operation.

(o) *Medical records system.* — The health maintenance organization shall maintain a health and medical records system that:

(1) Under procedures assuring maximum confidentiality, is readily accessible to authorized persons;

(2) Can accurately document use by each member; and

(3) At a minimum:

(i) Identifies clearly each patient by:

1. Name;
2. Number;
3. Age; and
4. Sex; and

(ii) Shows clearly:

1. The services provided;
2. When the services are provided;
3. Where the services are provided;
4. By whom the services are provided;
5. The diagnosis and prognosis, if appropriate;
6. The treatment;
7. Any drug therapy; and
8. The health status of the patient, if appropriate.

(p) *Enrollee not liable for covered services; exceptions.* — (1) Except as provided in paragraph (3) of this subsection, individual enrollees and subscribers of health maintenance organizations issued certificates of authority to operate in this State shall not be liable to any health care provider for any covered services provided to the enrollee or subscriber.

(2) (i) A health care provider or any representative of a health care provider may not collect or attempt to collect from any subscriber or enrollee any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(ii) A health care provider or any representative of a health care provider may not maintain any action against any subscriber or enrollee to collect or attempt to collect any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(3) Notwithstanding any other provision of this subsection, a health care provider or representative of a health care provider may collect or attempt to collect from a subscriber or enrollee:

(i) Any copayment or coinsurance sums owed by the subscriber or enrollee to a health maintenance organization issued a certificate of authority to operate in this State for covered services provided by the health care provider;

(ii) If Medicare is the primary insurer and a health maintenance organization is the secondary insurer, any amount up to the Medicare approved or limiting amount, as specified under the Social Security Act, that is

not owed to the health care provider by Medicare or the health maintenance organization after coordination of benefits has been completed, for Medicare covered services provided to the subscriber or enrollee by the health care provider; or

(iii) Any payment or charges for services that are not covered services.

(q) *Insolvency plan.* — (1) The Commissioner shall require each health maintenance organization to have an insolvency plan by January 1, 1990 which provides for:

(i) Continuation of benefits to subscribers and enrollees for the duration of the contract period for which premiums have been paid; and

(ii) Continuation of benefits to subscribers or enrollees who are admitted to an inpatient health care facility on the date of insolvency until, the earlier of:

1. The subscriber or enrollee is discharged from the inpatient health care facility; or

2. 365 days.

(2) In determining the adequacy of any insolvency plan, the Commissioner may consider:

(i) The existence of insurance to cover expenses incurred in continuing benefits after an insolvency;

(ii) Provisions in provider contracts obligating providers to continue to provide services to enrollees or subscribers:

1. For the duration of the contract period for which premiums have been made; and

2. If admitted to an inpatient health care facility, until the enrollee or subscriber is discharged or 365 days, whichever occurs first;

(iii) Reserves;

(iv) Letters of credit;

(v) Guarantees; or

(vi) Any other arrangement to assure that benefits are continued in accordance with the provisions of paragraph (1) of this subsection.

(r) *Collection by emergency facility for nonemergency.* — Repealed by Acts 1996, ch. 503, § 1, effective July 1, 1996.

(s) *Practice profiles.* — (1) In this subsection, "practice profile" means a profile, summary, economic analysis, or other analysis of data concerning services rendered or utilized by a provider under contract with or employed by a health maintenance organization for the provision of health care services by the provider to enrollees or subscribers of the health maintenance organization.

(2) If a health maintenance organization uses a practice profile as a factor in its contract review to evaluate a provider's status on a provider panel, the health maintenance organization shall disclose at the commencement and renewal of the contract and, not more often than annually, upon the request of the provider:

(i) A description of the criteria used to compile the practice profile concerning the provider; and

(ii) The manner in which the practice profile is used to evaluate the provider.

(3) The information provided under this subsection may not be used to create a cause of action.

(4) A health maintenance organization may not terminate a provider contract or provider's employment with the health maintenance organization on the basis of a practice profile without first informing the provider of the findings of the practice profile and the provider specific data underlying those findings.

(t) *Immunity prohibited.* — A health maintenance organization may not by contract, or in any other manner, require a provider to indemnify the health maintenance organization or hold the health maintenance organization harmless from a coverage decision or negligent act of the health maintenance organization. (An. Code 1957, art. 43, § 844; 1982, ch. 21, § 2; 1984, ch. 555; 1986, ch. 816; 1988, chs. 394, 703, 754; 1989, chs. 364, 610; 1991, ch. 121; 1993, ch. 635, § 2; 1996, ch. 503, § 1; ch. 548; 1997, ch. 70, § 4; 2000, ch. 275, § 1; ch. 331, §§ 1, 2; 2003, ch. 440, § 2; 2004, ch. 278.)

Effect of amendments. — Chapter 440, Acts 2003, effective Oct. 1, 2003, substituted "that are not covered services" for "not covered under the subscriber's contract" in (p)(3)(ii).

Chapter 278, Acts 2004, effective Oct. 1, 2004, reenacted (a) without change; and inserted present (p)(3)(ii) and redesignated former (p)(3)(ii) as (iii).

Construction. — In providing that a member is not liable for monies owed to a health care provider by a health maintenance organization (HMO), subsection (o) of this section specifically concerns itself with the relationship between a member and a health care provider, not the relationship between the member and the HMO. Riemer v. Columbia Medical Plan, Inc., 358 Md. 222, 747 A.2d 677 (2000), superseded by statute on other grounds, Plein v. DOL, Licensing & Reg., 369 Md. 421, 800 A.2d 757 (2002).

Physician's fees. — A physician's contract with a health maintenance organization (HMO) governs his recovery of fees for services rendered to an HMO's subscribers; the physician may not collect fees (except copayments) from the HMO subscriber unless the contract lawfully provides to the contrary. Patel v. Healthplus, Inc., 112 Md. App. 251, 684 A.2d 904 (1996).

Ambulance services. — When the Baltimore City Fire Department provides emergency ambulance services to an Health Maintenance Organization (HMO) member, it acts as a "provider" of a "covered service" for purposes of the state HMO law; accordingly, the department is entitled to collect from the HMO the fee set by law; it may not seek payment from the HMO member. 89 Op. Att'y Gen. 53 (Mar. 19, 2004).

Billing practices. — A provider under contract with an HMO may not balance bill a member for any covered service; however, the provider may bill the member directly for any non-covered service. 83 Op. Att'y Gen. — (1998).

Claim of alleged violation of subsection (o) stayed. — In an ERISA action addressing liens and subrogation rights asserted by health care providers, and alleging that its assertion of liens and subrogation interests in certain recoveries violated provisions of § 19-701(f)(3) of this subtitle and subsection (o) of this section, the court stayed the action and denied plaintiff's motion to remand because the issues were identical with a case on appeal in the same circuit, and defendants failed to show that they would be prejudiced by the delay or that there was any likelihood that the Fourth Circuit would not reach the merits of the case before it. Popoola v. MD-Individual Practice Ass'n, — F. Supp. 2d — (D. Md. May 29, 2001).

Quoted in Med. & Chirurgical Faculty v. Aetna U.S. Healthcare, Inc., 221 F. Supp. 2d 618 (D. Md. 2002).

Cited in Popoola v. MD-Individual Practice Ass'n, 244 F. Supp. 2d 577 (D. Md. 2003).

§ 19-710.1. Payment to health care provider not under written contract [Amendment subject to abrogation].

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Enrollee" means a subscriber or member of the health maintenance organization.

(3) "Adjunct claims documentation" means an abstract of an enrollee's medical record which describes and summarizes the diagnosis and treatment of, and services rendered to, the enrollee, including, in the case of trauma rendered in a trauma center, an operative report, a discharge summary, a Maryland Ambulance Information Systems form, or a medical record.

(4) "Institute" means the Maryland Institute for Emergency Medical Services Systems.

(5) (i) "Trauma center" means a primary adult resource center, level I trauma center, level II trauma center, level III trauma center, or pediatric trauma center that has been designated by the institute to provide care to trauma patients.

(ii) "Trauma center" includes an out-of-state pediatric facility that has entered into an agreement with the institute to provide care to trauma patients.

(6) "Trauma patient" means a patient that is evaluated or treated in a trauma center and is entered into the State trauma registry as a trauma patient.

(7) "Trauma physician" means a licensed physician who has been credentialed or designated by a trauma center to provide care to a trauma patient at a trauma center.

(b) *In general.* — (1) In addition to any other provisions of this subtitle, for a covered service rendered to an enrollee of a health maintenance organization by a health care provider not under written contract with the health maintenance organization, the health maintenance organization or its agent:

(i) Shall pay the health care provider within 30 days after the receipt of a claim in accordance with the applicable provisions of this subtitle; and

(ii) Shall pay the claim submitted by:

1. A hospital at the rate approved by the Health Services Cost Review Commission;

2. A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of:

A. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; or

B. The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; and

3. Any other health care provider at the greater of:

A. 125% of the rate the health maintenance organization pays in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider under written contract with the health maintenance organization; or

B. The rate as of January 1, 2000 that the health maintenance organization paid in the same geographic area, as published by the Centers for

Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider not under written contract with the health maintenance organization.

(2) A health maintenance organization shall disclose, on request of a health care provider not under written contract with the health maintenance organization, the reimbursement rate required under paragraph (1) (ii)2 and 3 of this subsection.

(3) (i) Subject to subparagraph (ii) of this paragraph, a health maintenance organization may require a trauma physician not under contract with the health maintenance organization to submit appropriate adjunct claims documentation and to include on the uniform claim form a provider number assigned to the trauma physician by the health maintenance organization.

(ii) If a health maintenance organization requires a trauma physician to include a provider number on the uniform claim form in accordance with subparagraph (i) of this paragraph, the health maintenance organization shall assign a provider number to a trauma physician not under contract with the health maintenance organization at the request of the physician.

(4) A trauma center, on request from a health maintenance organization, shall verify that a licensed physician is credentialed or otherwise designated by the trauma center to provide trauma care.

(5) Notwithstanding the provisions of § 19-701(d) of this subtitle, for trauma care rendered to a trauma patient in a trauma center by a trauma physician, a health maintenance organization may not require a referral or preauthorization for a service to be covered.

(c) *Reimbursement.* — (1) A health maintenance organization may seek reimbursement from an enrollee for any payment under subsection (b) of this section for a claim or portion of a claim submitted by a health care provider and paid by the health maintenance organization that the health maintenance organization determines is the responsibility of the enrollee.

(2) The health maintenance organization may request and the health care provider shall provide adjunct claims documentation to assist in making the determination under paragraph (1) of this subsection or under subsection (b) of this section.

(d) *Filing of complaint or civil action.* — (1) A health care provider may enforce the provisions of this section by filing a complaint against a health maintenance organization with the Maryland Insurance Administration or by filing a civil action in a court of competent jurisdiction under § 1-501 or § 4-201 of the Courts Article.

(2) The Maryland Insurance Administration or a court shall award reasonable attorney fees if the complaint of the health care provider is sustained.

(e) *Penalties.* — In addition to any other penalties under this subtitle, the Commissioner may impose a penalty not to exceed $5,000 on any health maintenance organization which violates the provisions of this section if the violation is committed with such frequency as to indicate a general business practice of the health maintenance organization. (1991, ch. 121; 1993, ch. 304; 1997, ch. 199; 2000, ch. 275, § 2; 2001, ch. 423; 2002, ch. 250; 2003, ch. 440, § 3.)

Effect of amendments. — Chapter 250, Acts 2002, effective June 1, 2002, substituted "the Centers for Medicare and Medicaid Services" for "the Health Care Financing Administration" in (b) (1) (ii) 2 A; and inserted "as published by the Centers for Medicare and Medicaid Services" in (b) (1) (ii) 2 B, (b) (1) (ii) 3 A, and (b) (1) (ii) 3 B.

Chapter 440, Acts 2003, effective Oct. 1, 2003, deleted former (a)(3); redesignated former (a)(4) to be present (a)(3) and redesignated the remaining sections accordingly; and inserted present (b)(5).

Editor's note. — Section 3, ch. 275, Acts 2000, provides that "the Health Services Cost Review Commission, in consultation with the Maryland Health Care Commission, the Maryland Insurance Administration, health care providers, and health maintenance organizations, shall develop a methodology for ensuring reasonable payment to health care providers not under written contract with a health maintenance organization. The Commission shall report its findings and recommendations to the House Economic Matters Committee and the Senate Finance Committee, in accordance with § 2-1246 of the State Government Article, on or before January 1, 2002."

Section 4, ch. 275, Acts 2000, provides that "this Act applies to health care services rendered on or after October 1, 2000."

Section 5, ch. 275, Acts 2000, as amended by § 1, ch. 250, Acts 2002, provides that "Sections 2 and 4 of this Act shall take effect October 1, 2000 and, at the end of June 30, 2005, with no further action required by the General Assembly, Sections 2 and 4 of this Act shall be abrogated and of no further force and effect."

Section 2, ch. 423, Acts 2001, provides "that this Act shall apply to services rendered on or after October 1, 2001. It shall remain effective until the taking effect of the termination provision specified in Section 5 of Chapter 275 of the Acts of the General Assembly of 2000. If that termination provision takes effect, this Act shall be abrogated and of no further force and effect. This Act may not be interpreted to have any effect on that termination provision."

Section 2, ch. 250, Acts 2002, provides that:

"(a) The Maryland Health Care Commission and the Health Services Cost Review Commission shall jointly study and make recommendations to the House Economic Matters and Senate Finance Committees regarding health care provider reimbursements by commercial insurers, including health maintenance organizations, and self-pay patients in the State.

(b) In performing the study, the Commissions shall develop recommendations on the following issues:

(i) whether the State should maintain a prohibition against the balance billing of health maintenance organization subscribers for covered services;

(ii) the feasibility and desirability of the development of a provider rate setting system that would establish both minimum and maximum reimbursement levels for health care services delivered in the State;

(iii) the feasibility and desirability of expanding the hospital rate setting system to include reimbursement of hospital-based and university-based physicians;

(iv) the feasibility of establishing an uncompensated care fund to subsidize reimbursements to providers that deliver a disproportionate amount of uncompensated care to State residents, including emergency room physicians, trauma physicians, hospital-based and university-based physicians, and other health care providers as determined by the Commissions;

(v) the prevalence of health care provider reimbursement methodologies employed by commercial insurance carriers, including health maintenance organizations, that are based on provider licensure; and

(vi) the level of reimbursement provided by commercial payers in the State as a percentage of provider costs compared to reimbursement provided by public payers as a percentage of provider costs;

(c) It is the intent of the General Assembly that licensed entities and individuals including health insurers, nonprofit health service plans, health maintenance organizations, hospitals, physicians, and nonphysician providers cooperate with the Commissions in the execution of the study by providing data in a timely and complete manner.

(d) The findings and recommendations of the study shall be presented, subject to § 2-1246 of the State Government Article, to the House Economic Matters Committee and Senate Finance Committee on or before January 1, 2004."

Section 3, ch. 250, Acts 2002, provides that "on or before January 1, 2003, the Board of Nursing, in consultation with representatives of health maintenance organizations that operate in the State, shall report in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and House Environmental Matters Committee on whether health maintenance organizations in the State should:

(1) individually credential nurse practitioners; and

(2) allow for the designation by a member or subscriber of a nurse practitioner as a primary care provider."

Section 5, ch. 440, Acts 2003, effective Oct. 1, 2003 provides that "Section 4 of this Act shall take effect on the taking effect of the termination provision specified in Section 3 of Chapter

§ 19-710.1 Payment to health care provider not under written contract [Amendment subject to abrogation]

(2) Notwithstanding paragraph (1) of this subsection, a health care provider may assert any claim it may have against the receiver of the insolvent health maintenance organization. (1986, ch. 441; 1989, ch. 610; 1995, ch. 273; 1996, ch. 10, § 1; 1997, ch. 70, § 4; 2000, ch. 61, § 6; 2006, ch. 44.)

Effect of amendments. — Chapter 44, Acts 2006, enacted April 7, 2006, pursuant to art. II, § 17(b) of the Maryland Constitution and effective from the date of enactment, rewrote (d)(2), (d)(3), (e)(3), (e)(4) and (e)(5) without substantive change.

§ 19-710.1. Payment to health care provider not under written contract.

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Enrollee" means a subscriber or member of the health maintenance organization.

(3) "Adjunct claims documentation" means an abstract of an enrollee's medical record which describes and summarizes the diagnosis and treatment of, and services rendered to, the enrollee, including, in the case of trauma rendered in a trauma center, an operative report, a discharge summary, a Maryland Ambulance Information Systems form, or a medical record.

(4) "Institute" means the Maryland Institute for Emergency Medical Services Systems.

(5) (i) "Trauma center" means a primary adult resource center, level I trauma center, level II trauma center, level III trauma center, or pediatric trauma center that has been designated by the institute to provide care to trauma patients.

(ii) "Trauma center" includes an out-of-state pediatric facility that has entered into an agreement with the institute to provide care to trauma patients.

(6) "Trauma patient" means a patient that is evaluated or treated in a trauma center and is entered into the State trauma registry as a trauma patient.

(7) "Trauma physician" means a licensed physician who has been credentialed or designated by a trauma center to provide care to a trauma patient at a trauma center.

(b) *In general.* — (1) In addition to any other provisions of this subtitle, for a covered service rendered to an enrollee of a health maintenance organization by a health care provider not under written contract with the health maintenance organization, the health maintenance organization or its agent:

(i) Shall pay the health care provider within 30 days after the receipt of a claim in accordance with the applicable provisions of this subtitle; and

(ii) Shall pay the claim submitted by:

1. A hospital at the rate approved by the Health Services Cost Review Commission;

2. A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of:

A. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; or

B. The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; and

3. Any other health care provider at the greater of:

A. 125% of the rate the health maintenance organization pays in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider under written contract with the health maintenance organization; or

B. The rate as of January 1, 2000 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider not under written contract with the health maintenance organization.

(2) A health maintenance organization shall disclose, on request of a health care provider not under written contract with the health maintenance organization, the reimbursement rate required under paragraph (1)(ii)2 and 3 of this subsection.

(3) (i) Subject to subparagraph (ii) of this paragraph, a health maintenance organization may require a trauma physician not under contract with the health maintenance organization to submit appropriate adjunct claims documentation and to include on the uniform claim form a provider number assigned to the trauma physician by the health maintenance organization.

(ii) If a health maintenance organization requires a trauma physician to include a provider number on the uniform claim form in accordance with subparagraph (i) of this paragraph, the health maintenance organization shall assign a provider number to a trauma physician not under contract with the health maintenance organization at the request of the physician.

(4) A trauma center, on request from a health maintenance organization, shall verify that a licensed physician is credentialed or otherwise designated by the trauma center to provide trauma care.

(5) Notwithstanding the provisions of § 19-701(d) of this subtitle, for trauma care rendered to a trauma patient in a trauma center by a trauma physician, a health maintenance organization may not require a referral or preauthorization for a service to be covered.

(c) *Reimbursement.* — (1) A health maintenance organization may seek reimbursement from an enrollee for any payment under subsection (b) of this section for a claim or portion of a claim submitted by a health care provider and paid by the health maintenance organization that the health maintenance organization determines is the responsibility of the enrollee.

(2) The health maintenance organization may request and the health care provider shall provide adjunct claims documentation to assist in making the determination under paragraph (1) of this subsection or under subsection (b) of this section.

d) *Filing of complaint or civil action.* — (1) A health care provider may enforce the provisions of this section by filing a complaint against a health maintenance organization with the Maryland Insurance Administration or by filing a civil action in a court of competent jurisdiction under § 1-501 or § 4-201 of the Courts Article.

(2) The Maryland Insurance Administration or a court shall award reasonable attorney fees if the complaint of the health care provider is sustained.

(e) *Penalties.* — In addition to any other penalties under this subtitle, the Commissioner may impose a penalty not to exceed $5,000 on any health maintenance organization which violates the provisions of this section if the violation is committed with such frequency as to indicate a general business practice of the health maintenance organization. (1991, ch. 121; 1993, ch. 304; 1997, ch. 199; 2000, ch. 275, § 2; 2001, ch. 423; 2002, ch. 250; 2003, ch. 440, § 3.)

Editor's note.

Section 5, ch. 275, Acts 2000, as amended by ch. 250, Acts 2002, as amended by ch. 295, Acts 2005, provides that "Sections 2 and 4 of this Act shall take effect October 1, 2000".

Section 3, ch. 423, Acts 2001, as amended by § 1, ch. 250, Acts 2002, as amended by ch. 295, Acts 2005, provides that "this Act shall take effect October 1, 2001."

Section 5, ch. 440, Acts 2003, effective Oct. 1, 2003 provides that "Section 4 of this Act shall take effect on the taking effect of the termination provision specified in Section 3 of Chapter 423 of the Acts of the General Assembly of 2001. If that termination provision takes effect, Section 3 of this Act shall be abrogated and of no further force and effect. This Act may not be interpreted to have any effect on that termination provision." Chapter 295, Acts 2005, deleted the abrogation provision of § 3, ch. 423.

19-712.7. Reimbursement to community health resources.

To the extent required under federal law, a health maintenance organization shall reimburse a community health resource, as defined in § 19-2101 of this title, for covered services provided to a member or subscriber of the Health Maintenance Organization. (2005, ch. 280, § 2.)

Editor's note. — Section 14, ch. 280, Acts 2005, provides in part that the act shall take effect July 1, 2005.

Bill review letter. — Chapter 280, Acts 2005 (House Bill 627) was approved for constitutionality and legal sufficiency; to the extent that there is any conflict between House Bill 627 and House Bill 147, "Budget Reconciliation and Financing Act of 2005," or Senate Bill 210, "Department of Health and Mental Hygiene - Federally Qualified Health Centers Grant Program," or Senate Bill 895, "Department of Health and Mental Hygiene - Maryland Health Insurance Plan - Computerized Eligibility System," which cannot be reconciled, assuming that both bills are signed, the language in the last signed will prevail. (Letter of the Attorney General dated May 10, 2005.)

§ 19-713.2. Administrative service provider contracts.

Illegal termination of contract by HMO. — Health maintenance organization (HMO) breached a contract with debtor, a health care provider, when it terminated the contract prior to the expiration of its term. The ultimate liability of the HMO to pay the claims was not limited to the amount of the letter of credit that it posted. Doctors Health, Inc. v. Nylcare Health Plans of the Mid-Atlantic, Inc. (In re Doctors Health, Inc.), 335 B.R. 95 (Bankr. D. Md. 2005).

Contract executory despite bankruptcy. — Contract where a debtor agreed to serve as the exclusive manager to provide medical ser-

§ 15-112. Provider Panels

TITLE 15.

HEALTH INSURANCE.

Subtitle 1. General Provisions.

§ 15-112. Provider panels.

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Ambulatory surgical facility" has the meaning stated in § 19-3B-01 of the Health - General Article.

(3) (i) "Carrier" means:

1. an insurer;
2. a nonprofit health service plan;
3. a health maintenance organization;
4. a dental plan organization; or
5. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(4) "Enrollee" means a person entitled to health care benefits from a carrier.

(5) "Hospital" has the meaning stated in § 19-301 of the Health - General Article.

(6) "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

(7) (i) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(ii) "Provider panel" does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee-for-service rate.

(b) *Establishment of procedures by carrier.* — (1) A carrier that uses a provider panel shall:

(i) 1. if the carrier is an insurer, nonprofit health service plan, or dental plan organization, maintain standards in accordance with regulations adopted by the Commissioner for availability of health care providers to meet the health care needs of enrollees; and

2. if the carrier is a health maintenance organization, adhere to the standards for accessibility of covered services in accordance with regulations adopted under § 19-705.1(b)(1)(ii) of the Health - General Article; and

(ii) establish procedures to:

1. review applications for participation on the carrier's provider panel in accordance with this section;

2. notify an enrollee of:

A. the termination from the carrier's provider panel of the primary care provider that was furnishing health care services to the enrollee; and

B. the right of the enrollee, on request, to continue to receive health care services from the enrollee's primary care provider for up to 90 days after the date of the notice of termination of the enrollee's primary care provider from the carrier's provider panel, if the termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status;

3. notify primary care providers on the carrier's provider panel of the termination of a specialty referral services provider;

4. verify with each provider on the carrier's provider panel, at the time of credentialing and recredentialing, whether the provider is accepting new patients and update the information on participating providers that the carrier is required to provide under subsection (j) of this section; and

5. notify a provider at least 90 days before the date of the termination of the provider from the carrier's provider panel, if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

(2) The provisions of paragraph (1)(ii)4 of this subsection may not be construed to require a carrier to allow a provider to refuse to accept new patients covered by the carrier.

(c) *Availability of application and information.* — A carrier that uses a provider panel:

(1) on request, shall provide an application and information that relates to consideration for participation on the carrier's provider panel to any provider seeking to apply for participation;

(2) shall make publicly available its application; and

(3) shall make efforts to increase the opportunity for a broad range of minority providers to participate on the carrier's provider panel.

(d) *Application procedure.* — (1) A provider that seeks to participate on a provider panel of a carrier shall submit an application to the carrier.

(2) (i) Subject to paragraph (3) of this subsection, the carrier, after reviewing the application, shall accept or reject the provider for participation on the carrier's provider panel.

(ii) If the carrier rejects the provider for participation on the carrier's provider panel, the carrier shall send to the provider at the address listed in the application written notice of the rejection.

(3) (i) Except as provided in paragraph (4) of this subsection, within 30 days after the date a carrier receives a completed application, the carrier shall send to the provider at the address listed in the application written notice of:

1. the carrier's intent to continue to process the provider's application to obtain necessary credentialing information; or

2. the carrier's rejection of the provider for participation on the carrier's provider panel.

(ii) The failure of a carrier to provide the notice required under subparagraph (i) of this paragraph is a violation of this article and the carrier is subject to the penalties provided by § 4-113(d) of this article.

(iii) If, under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its intent to continue to process the provider's application to obtain necessary credentialing information, the carrier, within 120 days after the date the notice is provided, shall:

1. accept or reject the provider for participation on the carrier's provider panel; and

2. send written notice of the acceptance or rejection to the provider at the address listed in the application.

(iv) The failure of a carrier to provide the notice required under subparagraph (iii)2 of this paragraph is a violation of this article and the carrier is subject to the provisions of and penalties provided by §§ 4-113 and 4-114 of this article.

(4) (i) A carrier that receives an incomplete application shall return the application to the provider at the address listed in the application within 10 days after the date the application is received.

(ii) The carrier shall indicate to the provider what information is needed to make the application complete.

(iii) The provider may return the completed application to the carrier.

(iv) After the carrier receives the completed application, the carrier is subject to the time periods established in paragraph (3) of this subsection.

(5) A carrier may charge a reasonable fee for an application submitted to the carrier under this section.

(e) *Prohibited denials and terminations — In general.* — A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of:

(1) gender, race, age, religion, national origin, or a protected category under the federal Americans with Disabilities Act;

(2) the type or number of appeals that the provider files under Subtitle 10B of this title;

(3) the number of grievances or complaints that the provider files on behalf of a patient under Subtitle 10A of this title; or

(4) the type or number of complaints or grievances that the provider files or requests for review under the carrier's internal review system established under subsection (h) of this section.

(f) *Same — Licensing, certification, and authorization.* — (1) A carrier may not deny an application for participation or terminate participation on its provider panel solely on the basis of the license, certification, or other authorization of the provider to provide health care services if the carrier provides health care services within the provider's lawful scope of practice.

(2) Notwithstanding paragraph (1) of this subsection, a carrier may reject an application for participation or terminate participation on its provider panel based on the participation on the provider panel of a sufficient number of similarly qualified providers.

(3) A violation of this subsection does not create a new cause of action.

(f-1) *Same — Recredentialing.* — (1) Subject to the provisions of this subsection, a carrier may not require a provider participating on its provider panel to be recredentialed based on:

(i) a change in the federal tax identification number of the provider;

(ii) a change in the federal tax identification number of a provider's employer; or

(iii) a change in the employer of a provider, if the new employer is:

1. a participating provider on the carrier's provider panel; or

2. the employer of providers that participate on the carrier's provider panel.

(2) A provider that participates on a carrier's provider panel or the provider's employer shall give written notice to the carrier of a change in the federal tax identification number of the provider or the provider's employer not less than 45 days before the effective date of the change.

(3) The notice required under paragraph (2) of this subsection shall include:

(i) a statement of the intention of the provider or the provider's employer to continue to provide health care services in the same field of specialization, if applicable;

(ii) the effective date of the change in the federal tax identification number of the provider or the provider's employer;

(iii) the new federal tax identification number of the provider or the provider's employer and a copy of U.S. Treasury Form W-9, or any successor or replacement form; and

(iv) the following information about a new employer of the provider:

1. the employer's name;

2. the name of the employer's contact person for carrier questions about the provider; and

3. the address, telephone number, facsimile transmission number, and electronic mail address of the contact person for the employer.

(4) If the new federal tax identification number or the form required to be included in the notice under paragraph (3)(iii) of this subsection is not available at the time the notice is given to a carrier, it shall be provided to the carrier promptly after it is received by the provider or the provider's employer.

(5) Within 30 business days after receipt of the notice required under paragraph (2) of this subsection, a carrier:

(i) shall acknowledge receipt of the notice to the provider or the provider's employer; and

(ii) if the carrier considers it necessary to issue a new provider number as a result of a change in the federal tax identification number of a provider or a provider's employer or a change in the employer of a provider, shall issue a new provider number, by mail, electronic mail, or facsimile transmission, to:

1. the provider or the provider's employer; or

2. the representative of the provider or the provider's employer designated in writing to the carrier.

(6) A carrier may not terminate its existing contract with a provider or a provider's employer based solely on a notice given to the carrier in accordance with this subsection.

(g) *Same — Advocating patient interests and filing appeals.* — A carrier may not terminate participation on its provider panel or otherwise penalize a provider for:

(1) advocating the interests of a patient through the carrier's internal review system established under subsection (h) of this section;

(2) filing an appeal under Subtitle 10B of this title; or

(3) filing a grievance or complaint on behalf of a patient under Subtitle 10A of this title.

(h) *Internal review system for grievances.* — Each carrier shall establish an internal review system to resolve grievances initiated by providers that participate on the carrier's provider panel, including grievances involving the termination of a provider from participation on the carrier's provider panel.

(i) *Continued care of enrollees after provider termination.* — (1) For at least 90 days after the date of the notice of termination of a primary care provider from a carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, the primary care provider shall furnish health care services to each enrollee:

(i) who was receiving health care services from the primary care provider before the notice of termination; and

(ii) who, after receiving notice under subsection (b) of this section of the termination of the primary care provider, requests to continue receiving health care services from the primary care provider.

(2) A carrier shall reimburse a primary care provider that furnishes health care services under this subsection in accordance with the primary care provider's agreement with the carrier.

(j) *Required information.* — (1) A carrier shall make available to prospective enrollees on the Internet and, on request of a prospective enrollee, in printed form:

(i) a list of providers on the carrier's provider panel; and

(ii) information on providers that are no longer accepting new patients.

(2) A carrier shall notify each enrollee at the time of initial enrollment and renewal about how to obtain the following information on the Internet and in printed form:

(i) a list of providers on the carrier's provider panel; and

(ii) information on providers that are no longer accepting new patients.

(3) (i) Information provided in printed form under paragraphs (1) and (2) of this subsection shall be updated at least once a year.

(ii) Subject to subsection (n) of this section, information provided on the Internet under paragraphs (1) and (2) of this subsection shall be updated at least once every 15 days.

(4) A policy, certificate, or other evidence of coverage shall:

(i) indicate clearly the office in the Administration that is responsible for receiving and responding to complaints from enrollees about carriers; and

(ii) include the telephone number of the office and the procedure for filing a complaint.

(k) *Duties of Commissioner.* — The Commissioner:

(1) shall adopt regulations that relate to the procedures that carriers must use to process applications for participation on a provider panel; and

(2) in consultation with the Secretary of Health and Mental Hygiene, shall adopt strategies to assist carriers in maximizing the opportunity for a broad range of minority providers to participate in the delivery of health care services.

(l) *"Health benefit plan" and "provider panel" defined; limitations of service on provider panels; termination; notice.* — (1) (i) In this subsection the following words have the meanings indicated.

(ii) 1. "Health benefit plan" has the meaning stated in § 15-1201 of this title.

2. "Health benefit plan" includes dental plans and other health benefit plans that contract with dentists to offer dental care services.

(iii) "Provider panel" includes an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee-for-service rate.

(2) Except as provided in paragraph (3) of this subsection, a carrier that offers coverage for health care services through one or more health benefit plans or contracts with providers to offer health care services through one or more provider panels may not require a provider, as a condition of participation or continuation on a provider panel for one health benefit plan of a carrier, to serve also on a provider panel of another health benefit plan of the carrier.

(3) Subject to § 15-102.5 of the Health - General Article, a carrier that offers health care services as a managed care organization as defined under § 15-101(e) of the Health - General Article, may require a provider, as a condition of participation on a provider panel for one or more health benefit plans of the carrier, to serve on a provider panel of the managed care organization.

(4) If a provider elects to terminate participation on the provider panel of a health benefit plan, the provider shall:

(i) notify the carrier at least 90 days before the date of termination; and

(ii) for at least 90 days after the date of the notice of termination, continue to furnish health care services to an enrollee of the carrier for whom the provider was responsible for the delivery of health care services prior to the notice of termination.

(m) *Prohibited conditions.* — A carrier may not include in a contract with a provider, ambulatory surgical facility, or hospital a term or condition that:

(1) prohibits the provider, ambulatory surgical facility, or hospital from offering to provide services to the enrollees of another carrier at a lower rate of reimbursement;

(2) requires the provider, ambulatory surgical facility, or hospital to provide the carrier with the same reimbursement arrangement that the provider, ambulatory surgical facility, or hospital has with another carrier if the reimbursement arrangement with the other carrier is for a lower rate of reimbursement; or

(3) requires the provider, ambulatory surgical facility, or hospital to certify to the carrier that the reimbursement rate being paid by the carrier to the provider, ambulatory surgical facility, or hospital is not higher than the reimbursement rate being received by the provider, ambulatory surgical facility, or hospital from another carrier.

(n) *Requirement to update provider information.* — (1) A carrier shall update its provider information under subsection (j)(3)(ii) of this section within 15 working days after receipt of written notification from the participating provider of a change in the applicable information.

(2) Notification is presumed to have been received by a carrier:

(i) 3 working days after the date the participating provider placed the notification in the U.S. mail, if the participating provider maintains the stamped certificate of mailing for the notice; or

(ii) on the date recorded by the courier, if the notification was delivered by courier. (An. Code 1957, art. 48A, § 490CC; 1997, ch. 35, § 2; 1998, ch. 111, § 2; ch. 112, § 2; 2000, chs. 253, 254, 279; 2001, ch. 157; 2003, ch. 259; 2004, ch. 25, § 5; 2006, ch. 44, § 6; chs. 54, 554, 597.)

Effect of amendments.

Chapter 54, Acts 2006, enacted April 7, 2006, pursuant to art. II, § 17(b) of the Maryland Constitution and effective from the date of enactment, substituted "120" for "150" in (d)(3)(iii); and added (f-1).

Chapter 554, Acts 2006, effective October 1, 2006, reenacted (a)(1) without change; added (a)(2) and (a)(5) with related changes; and added (m).

Chapter 597, Acts 2006, effective June 1, 2006, added (b)(1)(i)1 and (b)(1)(i)2; added (b)(1)(ii)4; redesignated former (b)(1)(ii)(4) as (b)(1)(ii)5; added (b)(2); added "Subject to subsection (m) of this section, information" at the beginning of (j)(3)(ii); and added (m) (now (n)).

Editor's note.

Section 6, ch. 44, Acts 2006, enacted April 7, 2006, pursuant to art. II, § 17(b) of the Maryland Constitution and effective from date of enactment, provides that "the publisher of the Annotated Code of Maryland, in consultation with and subject to the approval of the Department of Legislative Services, at the time of publication of a new supplement, new volume, or replacement volume of the Annotated Code, shall make nonsubstantive corrections to codification, style, capitalization, punctuation, grammar, spelling, and any reference rendered obsolete by an Act of the General Assembly, with no further action required by the General Assembly. The publisher shall adequately describe any such correction in an editor's note following the section affected." Pursuant to § 6 of ch. 44, in (a)(1), as it appeared in ch. 597, Acts 2006, the (i) designation was moved from the beginning to precede "1."; and in (j)(3)(ii), "subsection (n)" was substituted for "subsection (m)" following the amendment by ch. 554, Acts 2006.

Section 2, ch. 54, Acts 2006, provides that "(a) The Maryland Insurance Administration, in consultation with the Department of Health and Mental Hygiene, the Maryland Board of Physicians, and representatives of nonprofit health service plans, health insurers, health maintenance organizations, physicians, practice managers, hospitals, and other health care providers, shall:

"(1) compare the credentialing system for health providers used in the State to the systems used in other states;

"(2) compare the uniform credentialing form used in the State to the format used by the Council for Affordable Quality Healthcare;

"(3) identify the mechanisms used by physicians and other health care providers to complete credentialing; and

"(4) identify ways to improve the credentialing system used in the State.

"(b) On or before January 1, 2007, the Administration shall report its findings, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee."

Section 2, ch. 597, Acts 2006, provides that "(a) On or before January 1, 2007, the Maryland Insurance Administration, in consultation with the Department of Health and Mental Hygiene's Office of Health Care Quality and other interested and affected parties, shall adopt regulations to implement the provisions of § 15-112(b)(1)(i)1 of the Insurance Article, as enacted by Section 1 of this Act, with respect to insurers, nonprofit health service plans, and dental plan organizations.

"(b) In developing the regulations required under subsection (a) of this section, the Administration shall take into consideration the standards and procedures adopted by national accrediting organizations for preferred provider organizations and the laws of other states.

"(c) Each insurer, nonprofit health service plan, and dental plan organization offering preferred provider organization benefit plans in the State shall comply with the regulations on or before July 1, 2007."

Section 3, ch. 597, Acts 2006, provides that "(1) study the feasibility and desirability of imposing on carriers a network standard for in-network hospital-based physician services; and

"(2) report on the findings and recommendations of its study, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee."

Chapters 554 and 597, Acts 2006, each added (m). Neither of the 2006 amendments referred to the other, and the subsection added by ch. 597 has been redesignated as (n).

§ 15-125. Restrictions on assigning, transferring or subcontracting contracts.

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" means:

1. an insurer;
2. a nonprofit health service plan;
3. a health maintenance organization;
4. a dental plan organization; or
5. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(3) "Contract" means the implied or express agreement between a health care provider and carrier, including the rights, obligations, and fee schedule for the provision of health care services.

(4) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(b) *Carrier may not transfer contract or subcontract.* — (1) A carrier may not in any manner assign, transfer, or subcontract a health care provider's contract, wholly or partly, to an insurer that offers personal injury protection coverage under § 19-505 of this article without first informing the health care provider and obtaining the health care provider's express written consent.

(2) A carrier may not terminate, limit, or otherwise impair the contract or employment of a health care provider with the carrier on the basis that the health care provider refused to agree to an assignment, transfer, or subcontract of all or part of the health care provider's contract to an insurer that offers personal injury protection coverage under § 19-505 of this article.

§ 15-113. Compensation of health care practitioners.

(c) *Penalties.* — The Commissioner may impose a penalty not to exceed $500 against any carrier for each violation of this section by the carrier or its credentialing intermediary.

(d) *Regulations.* — (1) The Commissioner shall adopt regulations to implement the provisions of this section.

(2) In adopting the regulations required under paragraph (1) of this subsection, the Commissioner shall consider the use of an electronic format for the uniform credentialing form and the filing of the uniform credentialing form by electronic means. (1999, ch. 589.)

§ 15-113. Compensation of health care practitioners.

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(3) "Health care practitioner" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(b) *Reimbursement amounts.* — A carrier may not reimburse a health care practitioner in an amount less than the sum or rate negotiated in the carrier's provider contract with the health care practitioner.

(c) *Bonuses and other incentive-based compensation.* — This section does not prohibit a carrier from providing bonuses or other incentive-based compensation to a health care practitioner if the bonus or other incentive-based compensation:

(1) complies with the provisions of § 19-705.1 of the Health - General Article;

(2) promotes the delivery of medically appropriate care to an enrollee; and

(3) except for the provision of preventive health care services, is not based on the cost, or number of medical services provided, proposed, or recommended by the health care practitioner without reference to the medical appropriateness or necessity of the services.

(d) *Carrier to provide practitioner with certain information.* — (1) A carrier shall provide a health care practitioner with a written copy of:

(i) a schedule of applicable fees for up to the twenty most common services billed by a health care practitioner in that specialty;

(ii) a description of the coding guidelines used by the carrier that are applicable to the services billed by a health care practitioner in that specialty; and

(iii) the information about the practitioner and the methodology that the carrier uses to determine whether to:

1. increase or reduce the practitioner's level of reimbursement; and

2. provide a bonus or other incentive-based compensation to the practitioner.

(2) A carrier shall provide the information required under paragraph (1) of this subsection in each of the following instances:

(i) at the time of contract execution;

(ii) 30 days prior to a change; and

(iii) upon request of the health care practitioner.

(3) The Administration may adopt regulations to carry out the provisions of this subsection.

(e) *Compensation and compliance.* — (1) A carrier that compensates health care practitioners wholly or partly on a capitated basis may not retain any capitated fee attributable to an enrollee or covered person during an enrollee's or covered person's contract year.

(2) A carrier is in compliance with paragraph (1) of this subsection if, within 45 days after an enrollee or covered person chooses or obtains health care from a health care practitioner, the carrier pays to the health care practitioner all accrued but unpaid capitated fees attributable to that enrollee or person that the health care practitioner would have received had the enrollee or person chosen the health care practitioner at the beginning of the enrollee's or covered person's contract year. (An. Code 1957, art. 48A, § 490DD; 1997, ch. 35, § 2; 1998, chs. 192, 423, 424; 1999, chs. 255, 617.)

§ 15-114. Dental plans.

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides dental benefit plans subject to regulation by the State.

(3) "Dental point-of-service option" means a delivery system that allows an insured, enrollee, or other covered person under a dental benefit plan to receive dental services outside a provider panel.

(4) "Provider panel" means the providers that contract with a carrier to provide dental services to the carrier's insureds, enrollees, or other covered persons under the carrier's dental benefit plan.

(b) *Point-of-service option required.* — (1) If an employer, association, or other private group arrangement offers dental benefit plan coverage to employees or other individuals only through a carrier's provider panel, the carrier of the employer, association, or other private group arrangement shall offer, or contract with another carrier to offer, a dental point-of-service option to the employer, association, or other private group arrangement as an additional benefit for an employee or other individual, to accept or reject at the employee's or other individual's option.

§ 15-112. Provider Panels

TITLE 15.

HEALTH INSURANCE.

Subtitle 1. General Provisions.

§ 15-112. Provider panels.

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Ambulatory surgical facility" has the meaning stated in § 19-3B-01 of the Health - General Article.

(3) (i) "Carrier" means:

1. an insurer;
2. a nonprofit health service plan;
3. a health maintenance organization;
4. a dental plan organization; or
5. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(4) "Enrollee" means a person entitled to health care benefits from a carrier.

(5) "Hospital" has the meaning stated in § 19-301 of the Health - General Article.

(6) "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

(7) (i) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(ii) "Provider panel" does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee-for-service rate.

) *Establishment of procedures by carrier.* — (1) A carrier that uses a provider panel shall:

(i) 1. if the carrier is an insurer, nonprofit health service plan, or dental plan organization, maintain standards in accordance with regulations adopted by the Commissioner for availability of health care providers to meet the health care needs of enrollees; and

2. if the carrier is a health maintenance organization, adhere to the standards for accessibility of covered services in accordance with regulations adopted under § 19-705.1(b)(1)(ii) of the Health - General Article; and

(ii) establish procedures to:

1. review applications for participation on the carrier's provider panel in accordance with this section;

2. notify an enrollee of:

A. the termination from the carrier's provider panel of the primary care provider that was furnishing health care services to the enrollee; and

B. the right of the enrollee, on request, to continue to receive health care services from the enrollee's primary care provider for up to 90 days after the date of the notice of termination of the enrollee's primary care provider from the carrier's provider panel, if the termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status;

3. notify primary care providers on the carrier's provider panel of the termination of a specialty referral services provider;

4. verify with each provider on the carrier's provider panel, at the time of credentialing and recredentialing, whether the provider is accepting new patients and update the information on participating providers that the carrier is required to provide under subsection (j) of this section; and

5. notify a provider at least 90 days before the date of the termination of the provider from the carrier's provider panel, if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

(2) The provisions of paragraph (1)(ii)4 of this subsection may not be construed to require a carrier to allow a provider to refuse to accept new patients covered by the carrier.

(c) *Availability of application and information.* — A carrier that uses a provider panel:

(1) on request, shall provide an application and information that relates to consideration for participation on the carrier's provider panel to any provider seeking to apply for participation;

(2) shall make publicly available its application; and

(3) shall make efforts to increase the opportunity for a broad range of minority providers to participate on the carrier's provider panel.

(d) *Application procedure.* — (1) A provider that seeks to participate on a provider panel of a carrier shall submit an application to the carrier.

(2) (i) Subject to paragraph (3) of this subsection, the carrier, after reviewing the application, shall accept or reject the provider for participation on the carrier's provider panel.

(ii) If the carrier rejects the provider for participation on the carrier's provider panel, the carrier shall send to the provider at the address listed in the application written notice of the rejection.

(3) (i) Except as provided in paragraph (4) of this subsection, within 30 days after the date a carrier receives a completed application, the carrier shall send to the provider at the address listed in the application written notice of:

1. the carrier's intent to continue to process the provider's application to obtain necessary credentialing information; or

2. the carrier's rejection of the provider for participation on the carrier's provider panel.

(ii) The failure of a carrier to provide the notice required under subparagraph (i) of this paragraph is a violation of this article and the carrier is subject to the penalties provided by § 4-113(d) of this article.

(iii) If, under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its intent to continue to process the provider's application to obtain necessary credentialing information, the carrier, within 120 days after the date the notice is provided, shall:

1. accept or reject the provider for participation on the carrier's provider panel; and

2. send written notice of the acceptance or rejection to the provider at the address listed in the application.

(iv) The failure of a carrier to provide the notice required under subparagraph (iii)2 of this paragraph is a violation of this article and the carrier is subject to the provisions of and penalties provided by §§ 4-113 and 4-114 of this article.

(4) (i) A carrier that receives an incomplete application shall return the application to the provider at the address listed in the application within 10 days after the date the application is received.

(ii) The carrier shall indicate to the provider what information is needed to make the application complete.

(iii) The provider may return the completed application to the carrier.

(iv) After the carrier receives the completed application, the carrier is subject to the time periods established in paragraph (3) of this subsection.

(5) A carrier may charge a reasonable fee for an application submitted to the carrier under this section.

(e) *Prohibited denials and terminations — In general.* — A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of:

(1) gender, race, age, religion, national origin, or a protected category under the federal Americans with Disabilities Act;

(2) the type or number of appeals that the provider files under Subtitle 10B of this title;

(3) the number of grievances or complaints that the provider files on behalf of a patient under Subtitle 10A of this title; or

(4) the type or number of complaints or grievances that the provider files or requests for review under the carrier's internal review system established under subsection (h) of this section.

(f) *Same — Licensing, certification, and authorization.* — (1) A carrier may not deny an application for participation or terminate participation on its provider panel solely on the basis of the license, certification, or other authorization of the provider to provide health care services if the carrier provides health care services within the provider's lawful scope of practice.

(2) Notwithstanding paragraph (1) of this subsection, a carrier may reject an application for participation or terminate participation on its provider panel based on the participation on the provider panel of a sufficient number of similarly qualified providers.

(3) A violation of this subsection does not create a new cause of action.

(f-1) *Same — Recredentialing.* — (1) Subject to the provisions of this subsection, a carrier may not require a provider participating on its provider panel to be recredentialed based on:

(i) a change in the federal tax identification number of the provider;

(ii) a change in the federal tax identification number of a provider's employer; or

(iii) a change in the employer of a provider, if the new employer is:

1. a participating provider on the carrier's provider panel; or

2. the employer of providers that participate on the carrier's provider panel.

(2) A provider that participates on a carrier's provider panel or the provider's employer shall give written notice to the carrier of a change in the federal tax identification number of the provider or the provider's employer not less than 45 days before the effective date of the change.

(3) The notice required under paragraph (2) of this subsection shall include:

(i) a statement of the intention of the provider or the provider's employer to continue to provide health care services in the same field of specialization, if applicable;

(ii) the effective date of the change in the federal tax identification number of the provider or the provider's employer;

(iii) the new federal tax identification number of the provider or the provider's employer and a copy of U.S. Treasury Form W-9, or any successor or replacement form; and

(iv) the following information about a new employer of the provider:

1. the employer's name;

2. the name of the employer's contact person for carrier questions about the provider; and

3. the address, telephone number, facsimile transmission number, and electronic mail address of the contact person for the employer.

(4) If the new federal tax identification number or the form required to be included in the notice under paragraph (3)(iii) of this subsection is not available at the time the notice is given to a carrier, it shall be provided to the carrier promptly after it is received by the provider or the provider's employer.

(5) Within 30 business days after receipt of the notice required under paragraph (2) of this subsection, a carrier:

(i) shall acknowledge receipt of the notice to the provider or the provider's employer; and

(ii) if the carrier considers it necessary to issue a new provider number as a result of a change in the federal tax identification number of a provider or a provider's employer or a change in the employer of a provider, shall issue a new provider number, by mail, electronic mail, or facsimile transmission, to:

1. the provider or the provider's employer; or

2. the representative of the provider or the provider's employer designated in writing to the carrier.

(6) A carrier may not terminate its existing contract with a provider or a provider's employer based solely on a notice given to the carrier in accordance with this subsection.

(g) *Same — Advocating patient interests and filing appeals.* — A carrier may not terminate participation on its provider panel or otherwise penalize a provider for:

(1) advocating the interests of a patient through the carrier's internal review system established under subsection (h) of this section;

(2) filing an appeal under Subtitle 10B of this title; or

(3) filing a grievance or complaint on behalf of a patient under Subtitle 10A of this title.

(h) *Internal review system for grievances.* — Each carrier shall establish an internal review system to resolve grievances initiated by providers that participate on the carrier's provider panel, including grievances involving the termination of a provider from participation on the carrier's provider panel.

(i) *Continued care of enrollees after provider termination.* — (1) For at least 90 days after the date of the notice of termination of a primary care provider from a carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, the primary care provider shall furnish health care services to each enrollee:

(i) who was receiving health care services from the primary care provider before the notice of termination; and

(ii) who, after receiving notice under subsection (b) of this section of the termination of the primary care provider, requests to continue receiving health care services from the primary care provider.

(2) A carrier shall reimburse a primary care provider that furnishes health care services under this subsection in accordance with the primary care provider's agreement with the carrier.

(j) *Required information.* — (1) A carrier shall make available to prospective enrollees on the Internet and, on request of a prospective enrollee, in printed form:

(i) a list of providers on the carrier's provider panel; and

(ii) information on providers that are no longer accepting new patients.

(2) A carrier shall notify each enrollee at the time of initial enrollment and renewal about how to obtain the following information on the Internet and in printed form:

(i) a list of providers on the carrier's provider panel; and

(ii) information on providers that are no longer accepting new patients.

(3) (i) Information provided in printed form under paragraphs (1) and (2) of this subsection shall be updated at least once a year.

(ii) Subject to subsection (n) of this section, information provided on the Internet under paragraphs (1) and (2) of this subsection shall be updated at least once every 15 days.

(4) A policy, certificate, or other evidence of coverage shall:

(i) indicate clearly the office in the Administration that is responsible for receiving and responding to complaints from enrollees about carriers; and

(ii) include the telephone number of the office and the procedure for filing a complaint.

(k) *Duties of Commissioner.* — The Commissioner:

(1) shall adopt regulations that relate to the procedures that carriers must use to process applications for participation on a provider panel; and

(2) in consultation with the Secretary of Health and Mental Hygiene, shall adopt strategies to assist carriers in maximizing the opportunity for a broad range of minority providers to participate in the delivery of health care services.

(l) *"Health benefit plan" and "provider panel" defined; limitations of service on provider panels; termination; notice.* — (1) (i) In this subsection the following words have the meanings indicated.

(ii) 1. "Health benefit plan" has the meaning stated in § 15-1201 of this title.

2. "Health benefit plan" includes dental plans and other health benefit plans that contract with dentists to offer dental care services.

(iii) "Provider panel" includes an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee-for-service rate.

(2) Except as provided in paragraph (3) of this subsection, a carrier that offers coverage for health care services through one or more health benefit plans or contracts with providers to offer health care services through one or more provider panels may not require a provider, as a condition of participation or continuation on a provider panel for one health benefit plan of a carrier, to serve also on a provider panel of another health benefit plan of the carrier.

(3) Subject to § 15-102.5 of the Health - General Article, a carrier that offers health care services as a managed care organization as defined under § 15-101(e) of the Health - General Article, may require a provider, as a condition of participation on a provider panel for one or more health benefit plans of the carrier, to serve on a provider panel of the managed care organization.

(4) If a provider elects to terminate participation on the provider panel of a health benefit plan, the provider shall:

(i) notify the carrier at least 90 days before the date of termination; and

(ii) for at least 90 days after the date of the notice of termination, continue to furnish health care services to an enrollee of the carrier for whom the provider was responsible for the delivery of health care services prior to the notice of termination.

(m) *Prohibited conditions.* — A carrier may not include in a contract with a provider, ambulatory surgical facility, or hospital a term or condition that:

(1) prohibits the provider, ambulatory surgical facility, or hospital from offering to provide services to the enrollees of another carrier at a lower rate of reimbursement;

(2) requires the provider, ambulatory surgical facility, or hospital to provide the carrier with the same reimbursement arrangement that the provider, ambulatory surgical facility, or hospital has with another carrier if the reimbursement arrangement with the other carrier is for a lower rate of reimbursement; or

(3) requires the provider, ambulatory surgical facility, or hospital to certify to the carrier that the reimbursement rate being paid by the carrier to the provider, ambulatory surgical facility, or hospital is not higher than the reimbursement rate being received by the provider, ambulatory surgical facility, or hospital from another carrier.

(n) *Requirement to update provider information.* — (1) A carrier shall update its provider information under subsection (j)(3)(ii) of this section within 15 working days after receipt of written notification from the participating provider of a change in the applicable information.

(2) Notification is presumed to have been received by a carrier:

(i) 3 working days after the date the participating provider placed the notification in the U.S. mail, if the participating provider maintains the stamped certificate of mailing for the notice; or

(ii) on the date recorded by the courier, if the notification was delivered by courier. (An. Code 1957, art. 48A, § 490CC; 1997, ch. 35, § 2; 1998, ch. 111, § 2; ch. 112, § 2; 2000, chs. 253, 254, 279; 2001, ch. 157; 2003, ch. 259; 2004, ch. 25, § 5; 2006, ch. 44, § 6; chs. 54, 554, 597.)

Effect of amendments.

Chapter 54, Acts 2006, enacted April 7, 2006, pursuant to art. II, § 17(b) of the Maryland Constitution and effective from the date of enactment, substituted "120" for "150" in (d)(3)(iii); and added (f-1).

Chapter 554, Acts 2006, effective October 1, 2006, reenacted (a)(1) without change; added (a)(2) and (a)(5) with related changes; and added (m).

Chapter 597, Acts 2006, effective June 1, 2006, added (b)(1)(i)1 and (b)(1)(i)2; added (b)(1)(ii)4; redesignated former (b)(1)(ii)(4) as (b)(1)(ii)5; added (b)(2); added "Subject to subsection (m) of this section, information" at the beginning of (j)(3)(ii); and added (m) (now (n)).

Editor's note.

Section 6, ch. 44, Acts 2006, enacted April 7, 2006, pursuant to art. II, § 17(b) of the Maryland Constitution and effective from date of enactment, provides that "the publisher of the Annotated Code of Maryland, in consultation with and subject to the approval of the Department of Legislative Services, at the time of publication of a new supplement, new volume, or replacement volume of the Annotated Code, shall make nonsubstantive corrections to codification, style, capitalization, punctuation, grammar, spelling, and any reference rendered obsolete by an Act of the General Assembly, with no further action required by the General Assembly. The publisher shall adequately describe any such correction in an editor's note following the section affected." Pursuant to § 6 of ch. 44, in (a)(1), as it appeared in ch. 597, Acts 2006, the (i) designation was moved from the beginning to precede "1."; and in (j)(3)(ii), "subsection (n)" was substituted for "subsection (m)" following the amendment by ch. 554, Acts 2006.

Section 2, ch. 54, Acts 2006, provides that "(a) The Maryland Insurance Administration, in consultation with the Department of Health and Mental Hygiene, the Maryland Board of Physicians, and representatives of nonprofit health service plans, health insurers, health maintenance organizations, physicians, practice managers, hospitals, and other health care providers, shall:

"(1) compare the credentialing system for health providers used in the State to the systems used in other states;

"(2) compare the uniform credentialing form used in the State to the format used by the Council for Affordable Quality Healthcare;

"(3) identify the mechanisms used by physicians and other health care providers to complete credentialing; and

"(4) identify ways to improve the credentialing system used in the State.

"(b) On or before January 1, 2007, the Administration shall report its findings, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee."

Section 2, ch. 597, Acts 2006, provides that "(a) On or before January 1, 2007, the Maryland Insurance Administration, in consultation with the Department of Health and Mental Hygiene's Office of Health Care Quality and other interested and affected parties, shall adopt regulations to implement the provisions of § 15-112(b)(1)(i)1 of the Insurance Article, as enacted by Section 1 of this Act, with respect to insurers, nonprofit health service plans, and dental plan organizations.

"(b) In developing the regulations required under subsection (a) of this section, the Administration shall take into consideration the standards and procedures adopted by national accrediting organizations for preferred provider organizations and the laws of other states.

"(c) Each insurer, nonprofit health service plan, and dental plan organization offering preferred provider organization benefit plans in the State shall comply with the regulations on or before July 1, 2007."

Section 3, ch. 597, Acts 2006, provides that "(1) study the feasibility and desirability of imposing on carriers a network standard for in-network hospital-based physician services; and

"(2) report on the findings and recommendations of its study, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee."

Chapters 554 and 597, Acts 2006, each added (m). Neither of the 2006 amendments referred to the other, and the subsection added by ch. 597 has been redesignated as (n).

§ 15-125. Restrictions on assigning, transferring or subcontracting contracts.

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" means:

1. an insurer;
2. a nonprofit health service plan;
3. a health maintenance organization;
4. a dental plan organization; or
5. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(3) "Contract" means the implied or express agreement between a health care provider and carrier, including the rights, obligations, and fee schedule for the provision of health care services.

(4) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(b) *Carrier may not transfer contract or subcontract.* — (1) A carrier may not in any manner assign, transfer, or subcontract a health care provider's contract, wholly or partly, to an insurer that offers personal injury protection coverage under § 19-505 of this article without first informing the health care provider and obtaining the health care provider's express written consent.

(2) A carrier may not terminate, limit, or otherwise impair the contract or employment of a health care provider with the carrier on the basis that the health care provider refused to agree to an assignment, transfer, or subcontract of all or part of the health care provider's contract to an insurer that offers personal injury protection coverage under § 19-505 of this article.

(c) *Required service on provider panel for workers' compensation services prohibited.* — (1) A carrier that uses a provider panel for health care services may not require a health care provider, as a condition of participation or continuation on the carrier's provider panel for health care services, to also serve on a provider panel for workers' compensation services.

(2) A carrier may not terminate, limit, or otherwise impair a contract or an agreement with a health care provider, or terminate or limit the employment of a health care provider, based on the health care provider's election not to serve on a provider panel for workers' compensation services.

(3) A carrier shall include in a contract or an agreement with a health care provider a disclosure that informs the health care provider of the right to elect not to serve on a provider panel for workers' compensation services. (1998, ch. 417; 1999, ch. 698; 2006, ch. 476.)

Effect of amendments. — Chapter 476, Acts 2006, effective July 1, 2006, added (c).

Editor's note. — Section 2, ch. 476, Acts 2006, provides that "(a) This Act shall apply to contracts or agreements between health insurance carriers and health care providers that are executed on or after July 1, 2006.

"(b) This Act may not be construed to authorize a health care provider to terminate, limit, or otherwise impair any contract or agreement with a health insurance carrier that was executed on or before June 30, 2006."

§ 15-131. Electronic reimbursement.

(a) *Scope.* — This section applies to:

(1) insurers and nonprofit health service plans that provide, directly or through a pharmacy benefit manager, coverage for prescription drugs under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide, directly or through a pharmacy benefit manager, coverage for prescription drugs under contracts that are issued or delivered in the State.

(b) *In general.* — If an entity subject to this section requires a pharmacy to submit a request for payment electronically, then the pharmacy or designated agent may choose to be reimbursed electronically, and in that event the entity shall reimburse the pharmacy electronically, and shall provide the appropriate payment data electronically.

(c) *Processing fees prohibited.* — An entity subject to this section may not impose a processing fee for the electronic reimbursement or for providing payment data electronically. (2005, ch. 372.)

Editor's note. — Section 2, ch. 372, Acts 2005, provides that the act shall take effect October 1, 2006.

Subtitle 4. Eligibility for Coverage; Continuation and Conversion of Policies.

§ 15-417. Coverage for part-time students with disabilities.

(a) *Applicability.* — This section applies to: